Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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|---|---|
| **Facility's Name: Hawaii Kai ARCH** | **CHAPTER 100.1** |
| **Address:**<br>**308 Kuliouou Road, Honolulu, Hawaii 96821** | **Inspection Date: February 12, 2019 Annual** |

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements. (b)<br>All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.<br><br>**FINDINGS**<br>• Record of positive PPD history not available for review for Primary Care Giver (PCG) and Substitute Care Giver #1 (SCG #1)<br>• Record of two-step PPD history not available for review for Substitute Care Giver #2 (SCG #2) | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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| ☒ | §11-100.1-15 Medications. (n)<br>Self administration of medication shall be permitted when it is determined to be a safe practice by the resident, family, legal guardian, surrogate or case manager and primary care giver and authorized by the physician or APRN. Written procedures shall be available for storage, monitoring and documentation.<br><br>**FINDINGS**<br>Resident #2 – Over the counter supplements being stored in residents bedside table. No Physician's order. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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| ☒ | §11-100.1-16 Personal care services. (j)<br>Resident(s) manifesting behaviors that may cause injury to self or others shall be assessed by a physician or APRN to determine least restrictive alternatives to physical restraint use, which may be used only in an emergency when necessary to protect the resident from injury to self or to others. If restraint use is determined to be required and ordered by the resident's physician or APRN, the resident and the resident's family, guardian or surrogate, and case manager shall be notified and a written consent obtained. The licensee shall maintain a written policy for restraint use outlining resident assessment processes, indications for use, monitoring and evaluation and training of licensee and substitute care givers. Renewal orders for restraint use shall be obtained on a weekly basis from the resident's physician or APRN based on the assessment, monitoring and evaluation data presented by the primary care giver.<br><br>**FINDINGS**<br>Resident #1 – Bedside rails in use. No restraint policy in place. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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| ☒ | §11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(D)<br>Residents' rights and responsibilities:<br><br>Each resident shall:<br><br>Physical restraints may only be used in an emergency when necessary to protect the resident from injury to self or to others. In such a situation the resident's physician or APRN shall be notified immediately to obtain an assessment for least restrictive alternatives to restraint use. If restraint use is determined to be necessary, written orders shall be obtained from the resident's physician or APRN indicating the form of restraint to be used, the length of time restraint shall be applied, the frequency of use and the alternative care that can be provided to the resident. If a less restrictive alternative to restraint exists, it must be used in lieu of the restraint. The resident's family, legal guardian, surrogate or representative, and case manager shall be notified if no alternative to restraint exists and a written consent shall be obtained for restraint use. The restraint use shall be in compliance with the Type I ARCH's written policy, as approved by the department;<br><br>**FINDINGS**<br>Resident #1 – Bedside rails in use. No Physician's order including restraint parameters or lesser restrictive alternatives in place. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____